STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	006106	A. BUILDING: _____ B. WING _____	C 10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL INDIANAPOLIS	1700 W 10TH ST INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of a State complaint. Complaint: IN00131833 Unsubstantiated, lack of sufficent evidence. Date of Survey: 10-31-13 Facility number: 006106 Surveyor: John Lee, R.N. Public Health Nurse Surveyor Kindred Hospital Indianapolis is in compliance with 410 IAC 15-1.5-2, Infection Control, and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules. QA: claughlin 11/12/13	S 000		